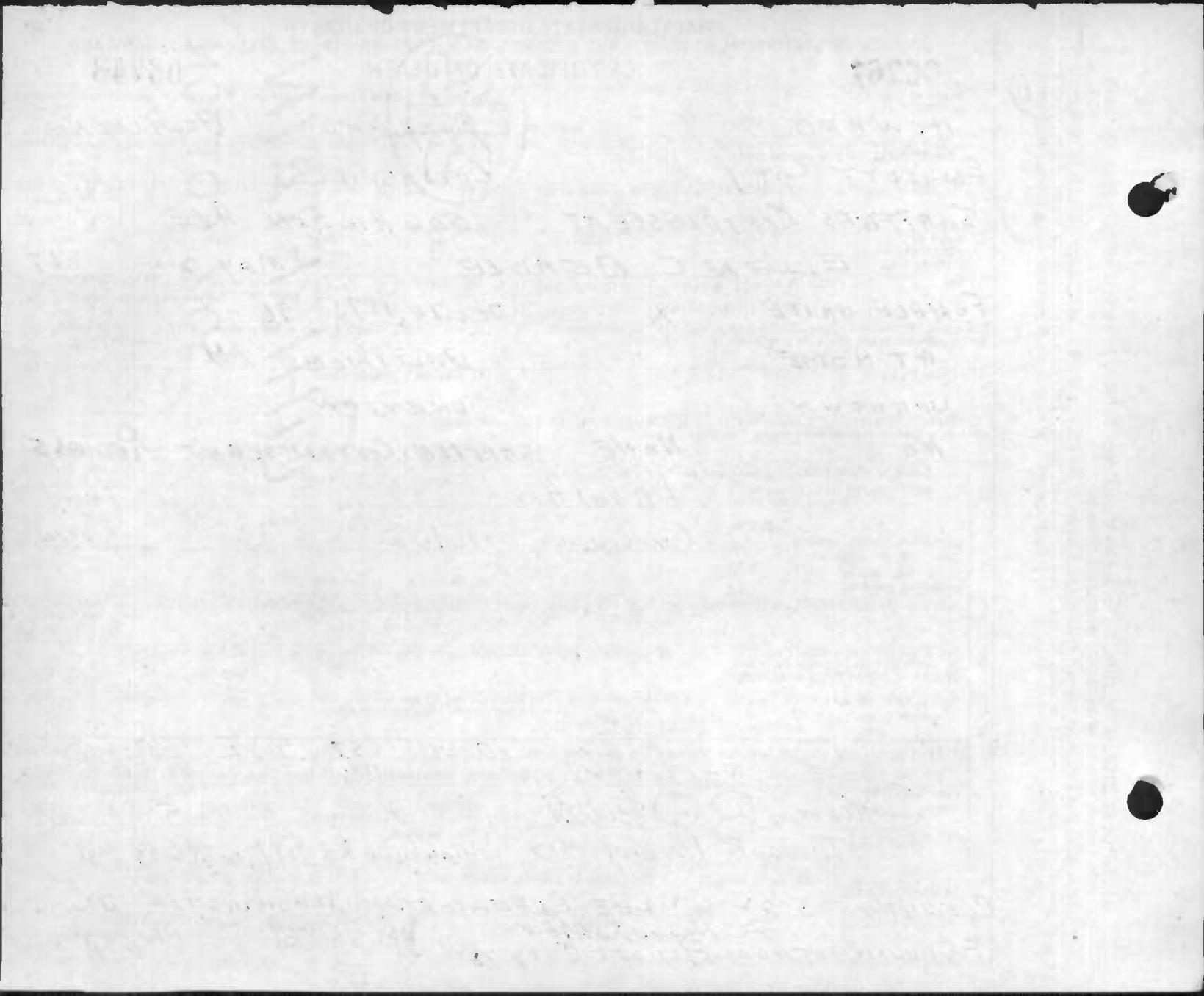


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																									
CERTIFICATE OF DEATH																									
06761				06748																					
1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE																					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ELLIOTT CITY				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE																					
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 506 HILTON AVE																					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SHAFFERS CONVALESCENT				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
3. NAME OF DECEASED (Type or print) ELLEN C. BEADERE				First MIDDLE Last				4. DATE OF DEATH MAY 22 1967																	
5. SEX FEMALE				6. COLOR OR RACE WHITE		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC 24, 1875															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME				10b. KIND OF BUSINESS OR INDUSTRY				9. AGE (In years last birthday) 91 yrs.				11. BIRTHPLACE (County & State, or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY?											
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. NONE				17. INFORMANT SHAFFERS CONVALESCENT - RECORDS		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1760 OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) OUE TO (c)				19. INTERVAL BETWEEN ONSET AND DEATH 1 month 8 months				20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Carcinoma, Uvula				21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20f. (City or town) (County) (State)							
		21. I certify that (I) (this hospital) attended the deceased from 10.28, 1967, to 5.22, 1967, that (I) (we) last saw the deceased alive on 5-19 1967, and that death occurred at 1760 M, from the causes and on the date stated above.				22a. SIGNATURE Thomas F. Herbert				22b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. DATE SIGNED 5.22.67											
22c. PHYSICIAN'S NAME (Type)		Thomas F. Herbert, MD				22d. ADDRESS 460 Church Rd, 911, Catonsville, MD				23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION				23b. DATE THEREOF 5-22-67				23c. NAME OF CEMETERY OR CREMATORIUM Lee Crematorium				23d. LOCATION (City, town or county) WASHINGTON D.C.			
24. FUNERAL DIRECTOR F. C. HIGGINBOTHAM, ELLIOTT C. T. MD		25a. ADDRESS 707 Negley Avenue				25b. REC'D BY REGISTRAR MAY 24 1967				25c. REGISTRAR'S SIGNATURE Charles J. Judge															



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 06762		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
a. COUNTY Howard		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge 27		b. COUNTY Howard	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge 27	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sherwood Acres Box 271		d. STREET ADDRESS Box 271	
3. NAME OF DECEASED (Type or print) ELLEN LOUISE CUNNINGHAM		4. DATE OF DEATH May 5, 1967 19	
5. SEX Female White		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		8. DATE OF BIRTH Mar. 15, 1913 54 yrs.	
11b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 12. CITIZEN OF WHAT COUNTRY? Elizabeth, W. Va.	
13. FATHER'S NAME P.S. Malone		14. MOTHER'S MAIDEN NAME Alice Underwood	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ? 17. INFORMANT Arlan D. Cunningham, Elkridge, Md. Box. 271	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 1950 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CARCINOMATOSIS (c) CARCINOMA OF OVARY		6 M 1 Year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-22, 1967, to 5-5, 1967, that (I) (we) last saw the deceased alive on 5-5, 1967, and that death occurred at 9:15 AM, from the causes and on the date stated above.			
22a. SIGNATURE Peter V. Hinchliffe		22b. DATE SIGNED 5-6-67	
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS	
23a. BURIAL, CREMATION, REMDVAL (Specify) Burial		23b. DATE THEREOF 5-8-1967	
23c. NAME OF CEMETERY OR CREMATORIUM Meadowridge		23d. LOCATION (City, town or county) (State) Elkridge, Md	
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md		25a. REC'D BY REGISTRAR MAY 8 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

06763

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06750

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY HOWARD		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. LENGTH OF STAY IN 1b MARYLAND	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		d. STREET ADDRESS 21227	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1935 Furnace Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MAURY		First JACKSON	Middle FUNK
4. DATE OF DEATH Month May	Day 31, 1967	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH Mar. 27, 1907	9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Opr.		10b. KIND OF BUSINESS OR INDUSTRY Tin and paper Co.	
11. BIRTHPLACE (State or foreign country) Ft. Valley, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Funk		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-03-1770	
17. INFORMANT Marvin Funk, 5401 Miami Ct., Elkridge 27, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in chest	
20c. TIME OF INJURY Month Day Year Hour o.m. 5-29 of ? p.m. 5-30 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
20f. (City or town) Elkridge		(County) Howard	
(State) Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Charles S. Springate, M.D.	
22. DATE SIGNED June 1, 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-3-1967	23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Memorial
23d. LOCATION (City or Town) Elkridge, Md		(County) (State)	
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md		25a. REC'D BY REGISTRAR DATE JUN 5 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06764

CERTIFICATE OF DEATH

DS751

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY Howard		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 629 Montgomery Road		d. STREET ADDRESS 629 Montgomery Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)	First CRUIS	Middle CARSON	Last GREGORY	4. DATE OF DEATH Month May 1, 1967	Month 19	Day 1967	Year 1967	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 8, 1917	9. AGE (in years last birthday) 50 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kaiser Alum	11. KIND OF BUSINESS OR INDUSTRY Pressmess, Tenn	12. CITIZEN OF WHAT COUNTRY? Parlee Seals
13. FATHER'S NAME Leonard Gregory	14. MOTHER'S MAIDEN NAME Carroll Gregory, 778 Oella Ave. Oella, Md		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 249-28-1145	17. INFORMANT Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PULMONARY EMPHYSEMA.										INTERVAL BETWEEN ONSET AND DEATH 12 hrs					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 7/23, 1967, to 5/1, 1967	(County) that (I) (we) last	(State) saw the deceased alive on 5/1, 1967, and that death occurred at 5:30 AM, from the causes and on the date stated above.					22b. DATE SIGNED 5/1/67				
22a. SIGNATURE Paul R. Ziegler	M.O. ATTENDING PHYS. PAUL R. ZIEGLER		22d. ADDRESS 2000 CASTLEHILL DR ELICOTT CITY, MD												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-6-1967	23c. NAME OF CEMETERY OR CREMATORIAL Highland	23d. LOCATION (City, town or county) Rogersville, Tenn	(State)											
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md	ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE											
DATE MAY 3 1967															

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> How.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Montgomery Clarksburg</i>		c. LENGTH OF STAY IN 1b <i>1 year</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Montgomery Clarksburg</i>		d. STREET ADDRESS <i>R. F. D. #2 Box 122</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>R. F. D. #2 Box 122</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Elizabeth M</i>		First <i>Middle</i> <i>Hightower</i> Last		4. DATE OF DEATH <i>May 7, 1967</i>		Month Day Year	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 26, 1888</i>	9. AGE (In years last birthday) <i>79 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Louisiana</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Benjamin J. Margot</i>		14. MOTHER'S MAIDEN NAME <i>Anna E. Reinhardt</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>579-60-5900</i>		17. INFORMANT <i>Mrs. Henry Greene</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Blurred vision, Dullness</i>		Address <i>R. F. D. #2 Box 122 Clarksville, Md.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Obstetric Indie</i>		DUE TO (b) <i>Excessive Use of Powers</i>		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 mo.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>411 1/2 517 1/2</i>		20f. (City or town) (County) (State) <i>Montgomery 1967 5/7/67</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>4/1/1967</i> to <i>5/7/1967</i> , that (I) (we) last saw the deceased alive on <i>5/6/1967</i> and that death occurred on <i>5/7/1967</i> , from causes and on the date stated above.							
22a. SIGNATURE <i>John</i>				M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>C. H. Johnson</i>				22d. ADDRESS <i>Sandy Spring Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>May 8, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Co. Md.</i>	
24. FUNERAL DIRECTOR <i>Glen Carter</i>		ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>MAY 11 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06766

CERTIFICATE OF DEATH

06753

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lisbon		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lisbon	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dorsey Middle L. Mullinix		4. DATE OF DEATH Month May Day 29 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (County & State, or foreign country) Montg. Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John J. Mullinix		14. MOTHER'S MAIDEN NAME Emily Purdum	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-0692 17. INFORMANT Address Jerome J. Mullinix, Finksburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carbuncle prostate</i> , 177X DUE TO <i>Cystitis, A STD, Cardiac</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Failure</i>		INTERVAL BETWEEN ONSET AND DEATH 1966 to 5-29-67	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1776
20f. (City or town) (County) (State)		5-29 1967	
21. I certify that (I) (this hospital) attended the deceased from 5-29 1967, to 5-29 1967, that (I) (we) lost saw the deceased alive on 5-29 1967, and that death occurred at 7 A.M. from causes and on the date stated above.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Howard E. Hall, M.D.		22d. ADDRESS Lykens, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 31, 1967 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Howard Chapel	
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		23d. LOCATION (City or Town) (County) (State) Long Corner, Md.	
25a. REC'D BY REGISTRAR DATE JUN 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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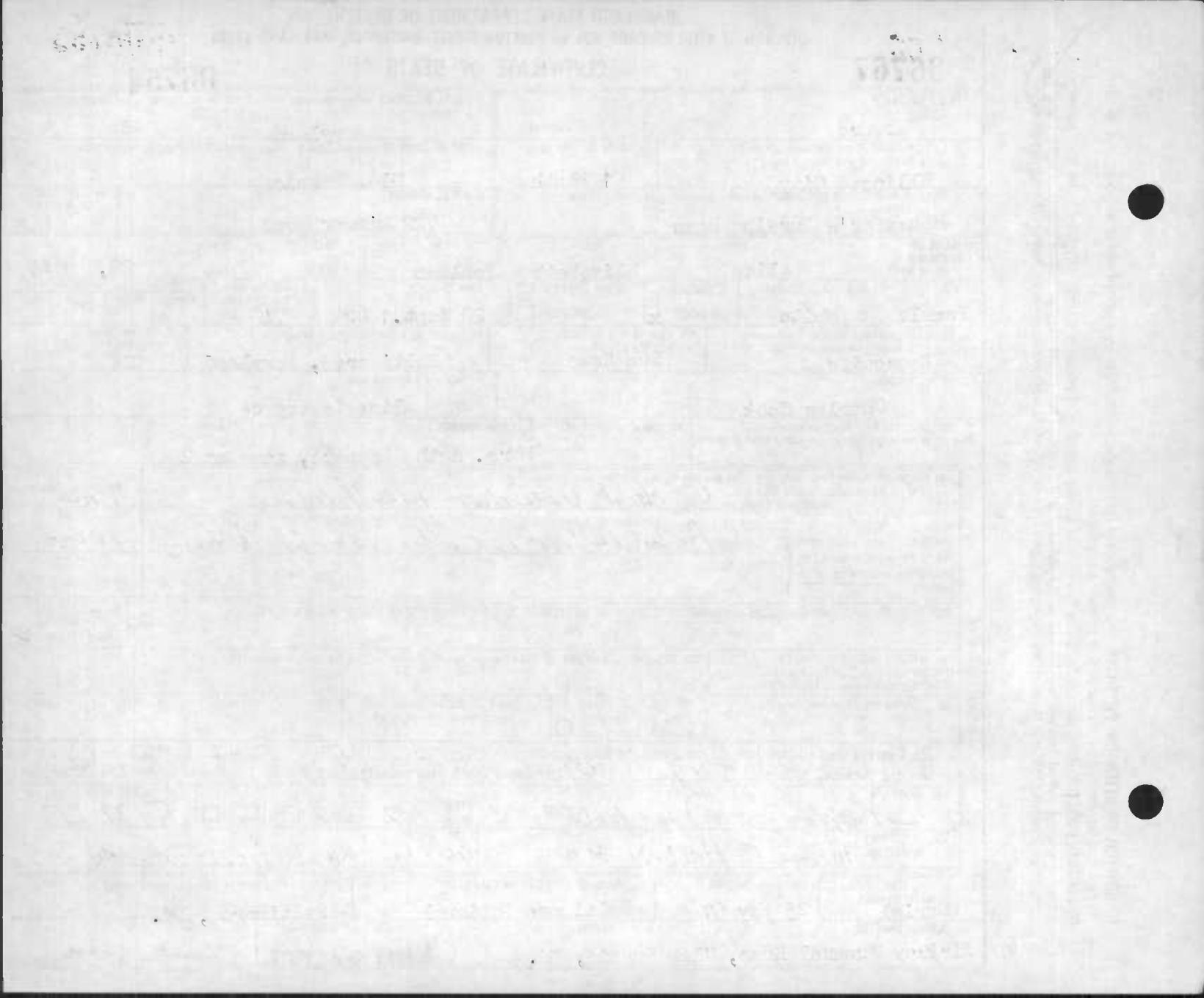
CERTIFICATE OF DEATH

06754

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY Howard MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN lb 1 Month	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		d. STREET ADDRESS 722 Wimmer Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Schaefer's Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice Elizabeth Pohlman		4. DATE OF DEATH May 22, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 28 Sept. 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years lost birthday) 74 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Charles Cook		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ruth Sheppard, same as 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		<i>Cerebral Vascular insufficiency</i>	
DUE TO (b)		<i>Arteriosclerotic Cardio-Vascular Disease</i>	
DUE TO (c)		10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 5-10, 1967 , to 5-22, 1967 , that (1) (we) last saw the deceased alive on 5-19, 1967 , and that death occurred of 5-22, 1967 M, from causes and on the date stated above		22b. DATE SIGNED 5-22-67	
22c. PHYSICIAN'S NAME (Type) Thomas F. Herbert, MD		22d. ADDRESS 44 Church Rd. Ellicott City, Md 21042	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 25 May 67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25a. REC'D BY REGISTRAR MAY 24 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

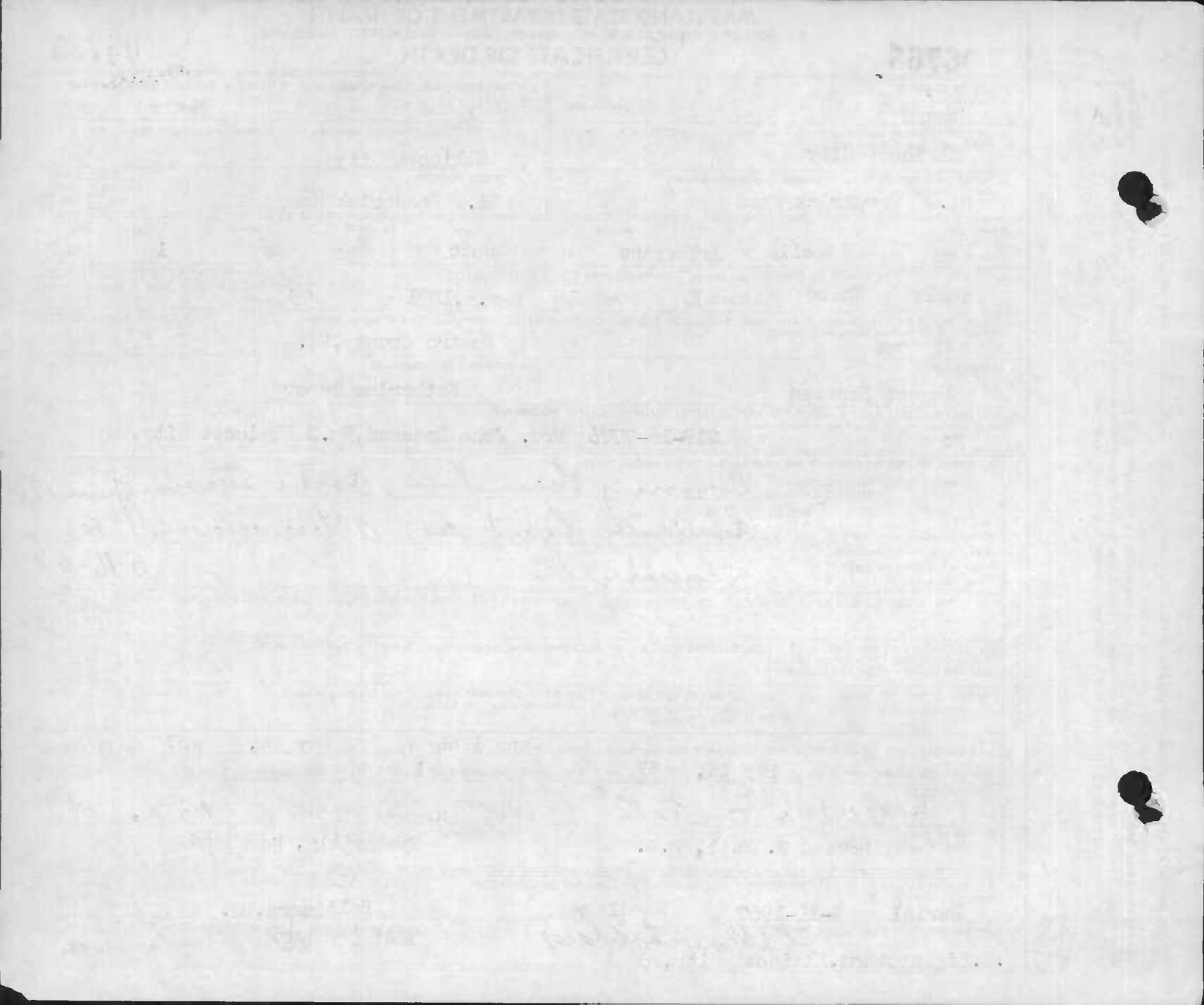
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

06768

06755

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		d. STREET ADDRESS Rt.2 Frederick Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt.2 Frederick Road				d. STREET ADDRESS Rt.2 Frederick Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Amelia	Middle Catherine	Last Scott	4. DATE OF DEATH May	Month May	Day 16	Year 1967	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1891		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Howard County, Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME August Kertsen			14. MOTHER'S MAIDEN NAME Katherine Super						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-16-7776		17. INFORMANT Mrs. John Redmond, Rt.2 Ellicott City, Md		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 <i>Coronary thrombosis, aortic stenosis</i> June 1966 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } DUE TO (b) <i>Rheumatic heart des, arteriosclerosis</i> to DUE TO (c) <i>Generalized</i> - 5-16-67 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 1966 19 to May 16, 1967, that (I) (we) last saw the deceased alive on May 16, 1967, and that death occurred at 1 AM, from the causes and on the date stated above.									22b. DATE SIGNED May 16, 1967
22a. SIGNATURE <i>Howard E. Hall</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) Howard E. Hall, M.D.		22d. ADDRESS Sykesville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-19-1967		23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn		23d. LOCATION (City, town, or county) Baltimore, Md.			(State)
24. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.		ADDRESS		25a. REGISTER BY REGISTRAR MAY 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			
				DATE					



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06757

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06770

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shaffers Convalescent Home		d. STREET ADDRESS 2526 Wycliffe Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First 10A	Middle M.
4. DATE OF DEATH Month May Doy 15 Year 1967		Lost STEFFEY	Month Month Doy Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. B. DATE OF BIRTH July 11, 1873.		9. AGE (In years old/birthday) 95 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eli B. Wantz		14. MOTHER'S MAIDEN NAME Charlotte Rineman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-50-6132	
17. INFORMANT Mr. Gideon H. Steffey		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Dehydration</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>h231</i> (b) <i>Inanition</i> DUE TO (c) <i>Arteriosclerotic cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH 2 days 1 wk 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <i>11-7-1966</i> to <i>5-15-1967</i> that (1) (we) last saw the deceased alive on <i>5-14-1967</i> and that death occurred at <i>64SP M</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Thomas P. Herbert</i>		22b. DATE SIGNED <i>5-15-67</i>	
22c. PHYSICIAN'S NAME (Type) Thomas P. Herbert, M.D.		22d. ADDRESS <i>Ellicott City Md. 21043</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/18/67.	
23c. NAME OF CEMETERY OR CREMATORIAL Greenmount E.U.B. Cemetery		23d. LOCATION (City or Town) (County) (State) Greenmount, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS	
		25a. REC'D BY REGISTRAR DATE <i>MAY 16 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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